UCSF Medical Center
Center for
Reproductive Health

PCOS Multidisciplinary Clinic

Last Name: _____ Today's Date: _____

First Name: _____ Date of Birth: _____

Middle Initial: _____ SSN: _____

Email Address: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

Referring Physician: _____

Address: _____

Phone: _____

Fax: _____

What is your Ancestry?

- ☐ African-American
- ☐ Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-Chinese
- ☐ Asian-Japanese
- ☐ Asian-Korean
- ☐ Asian-Indian
- ☐ Asian-Filipino
- ☐ Asian-Vietnamese
- ☐ Asian-Other: _____
- ☐ Caucasian-Northern European
- ☐ Caucasian-Russian
- ☐ Caucasian-Southern European
- ☐ Hispanic-Mexican
- ☐ Hispanic-South American Country of Origin: _____
- ☐ Hispanic-Central American Country of Origin: _____
- ☐ Hispanic-Spain
- ☐ Middle Eastern-Country of Origin: _____
- ☐ African-Country of Origin: _____
- ☐ Other (specify): _____

What is your Mother's Ancestry? (check all that apply)

- ☐ African-American
- ☐ Native American
- ☐ Ashkenazi Jewish
- ☐ Asian-Chinese
- ☐ Asian-Japanese
- ☐ Asian-Korean
- ☐ Asian-Indian
- ☐ Asian-Filipino
- ☐ Asian-Vietnamese
- ☐ Asian-Other: _____

☐ Caucasian-Northern European
☐ Caucasian-Russian
☐ Caucasian-Southern European
☐ Hispanic-Mexican
☐ Hispanic-South American Country of Origin: _____
☐ Hispanic-Central American Country of Origin: _____
☐ Hispanic-Spain
☐ Middle Eastern-Country of Origin: _____
☐ African-Country of Origin: _____
☐ Other (specify): _____

What is your Father's Ancestry? (check all that apply)

☐ African-American
☐ Native American
☐ Ashkenazi Jewish
☐ Asian-Chinese
☐ Asian-Japanese
☐ Asian-Korean
☐ Asian-Indian
☐ Asian-Filipino
☐ Asian-Vietnamese
☐ Asian-Other: _____
☐ Caucasian-Northern European
☐ Caucasian-Russian
☐ Caucasian-Southern European
☐ Hispanic-Mexican
☐ Hispanic-South American Country of Origin: _____
☐ Hispanic-Central American Country of Origin: _____
☐ Hispanic-Spain
☐ Middle Eastern-Country of Origin: _____
☐ African-Country of Origin: _____
☐ Other (specify): _____

Were you born in the United States? ☐ Yes ☐ No

If not, what country were you born in? _____

How long have you lived in the US? _____

Occupation: _____

Average Household Income:

☐ Less than $24,999
☐ $25,000-$49,999
☐ $50,000-$74,999
☐ $75,000-$99,999
☐ $100,000-$199,999
☐ Greater than $200,000

Highest Completed Grade Level

☐ Elementary school (K-6)
☐ Junior high school (7-8)
☐ High school (9-12)
☐ Some college
☐ College graduate
☐ Post graduate

Relationship Status

☐ Married
☐ Living with partner
☐ Significantly involved with a partner, but not living together
☐ Single/Not significantly involved
☐ Other, Specify: _____

Do you have children?

☐ Yes How many? _____
☐ No

Do smoke cigarettes?
☐ No
☐ Yes
☐ Quit? – when? _____

If yes, how many /day? _____
How many years? _____

Do you drink alcohol?
☐ No
☐ Yes

If yes,
☐ Beer - # per week: _____
☐ Wine - # per week: _____
☐ Liquor - # per week: _____

Do you use marijuana, cocaine, or any other similar drug?
☐ No
☐ Yes (describe): _____

Medical History

Do you have any medical problems?
☐ Yes
☐ No

If yes, please list type, dates, and treatments:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had any surgeries?
☐ Yes (Please list all surgeries in chronological order)
☐ No

Year	Reason and Type of Surgery

Are you allergic to any medications?
☐ Yes
☐ No

Please list and describe reactions: _____

List any medications your are currently taking, including over-the-counter and herbal medicines:

_____

_____

General

☐ Recent weight gain or loss
☐ Lack of energy
☐ Fever/Chills
☐ Other: _____
☐ No problems

Endocrine/Hormonal

☐ Diabetes
☐ Hair loss
☐ Thyroid gland problems
☐ Rapid weight gain or loss
☐ Excessive hunger/thirst
☐ Temperature intolerance- hot flashes

or feeling cold
- ☐ Other
- ☐ Excessive Hair Growth
- ☐ Acne
- ☐ No problems

Gastrointestinal

- ☐ Nausea/Vomiting
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hepatitis
- ☐ Blood in your stools
- ☐ Irritable Bowel Syndrome
- ☐ Change in bowel habits
- ☐ Colitis (ulcerative or Crohn's)
- ☐ Other: _____
- ☐ No problems

Genito-Urinary

- ☐ Bladder infections
- ☐ Kidney infections
- ☐ Vaginal infections
- ☐ Frequent urination
- ☐ Leaking urine
- ☐ Blood in the urine
- ☐ Herpes
- ☐ Other: _____
- ☐ No problems

Skin/Extremities

- ☐ Unexplained rash/inflammation
- ☐ Acne
- ☐ Skin cancer
- ☐ Burn injury
- ☐ Moles changing in appearance
- ☐ Excessive hair growth
- ☐ Other: _____
- ☐ No problems

Respiratory

- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Bloody cough
- ☐ Other: _____
- ☐ No problems

Head, Eyes, Ears, Nose & Throat

- ☐ Dizziness
- ☐ Headaches
- ☐ Loss of sense of smell
- ☐ Chronic nasal congestion
- ☐ Blurred vision
- ☐ Ringing ears
- ☐ Hearing loss/deafness
- ☐ Other: _____
- ☐ No problems

Neurological Problems

- ☐ Weakness/Loss of balance
- ☐ Seizures/Epilepsy
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Other: _____
- ☐ No problems

Musculoskeletal

- ☐ Unusual muscle weakness
- ☐ Decreased energy/stamina
- ☐ Rheumatoid arthritis
- ☐ Lupus Erythematosus
- ☐ Myasthenia gravis
- ☐ Other: _____
- ☐ No problems

Hematologic

- ☐ Blood clotting disorder/blood clot
- ☐ Sickle cell anemia
- ☐ Thrombophlebitis
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Blood transfusions
  (dates: _____ / reasons: _____)
- ☐ Other
- ☐ No problems

Cardiovascular

Mental Health Problems

- ☐ Palpitations/Skipped beats
- ☐ Chest pain
- ☐ Heart attack
- ☐ Stroke
- ☐ Murmurs
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Mitral valve prolapse
  Need antibiotics before dental procedures?
  - o Yes
  - o No
- ☐ Other: _____
- ☐ No problems

- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Other: _____
- ☐ No problems

Breasts

- ☐ Discharge
  - o Clear
  - o Bloody
  - o Milky
- ☐ Lumps
- ☐ Pain
- ☐ Cancer
- ☐ Abnormal mammogram
- ☐ Reduction
- ☐ Augmentation/Breast implants
  - o Saline
  - o Silicone
- ☐ Other: _____
- ☐ No problems

Eating Behaviors/Disorders

- ☐ Anorexia
- ☐ Bulimia
- ☐ Binge Eating
- ☐ Induced vomiting
- ☐ Laxative use
- ☐ Diuretic use
- ☐ Enema use
- ☐ Fasting (for weight loss)
- ☐ Excessive exercise
- ☐ Other: _____
- ☐ No problems

Which of the following are concerning to you?
Please rank only those that concern you.
(1= most concerning, 2= second most concerning, etc.)

_____ Menstrual Period
- ☐ Irregular
- ☐ Absent
- ☐ Other

_____ Excessive Hair Growth
_____ Scalp Hair Loss
_____ Acne
_____ Weight
_____ Fertility Concerns
_____ Depression
_____ Long-term Consequences
- ☐ Cholesterol problems (high cholesterol or triglycerides, low HDL)
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Uterine cancer

_____ Other: Please Specify _____

Please elaborate upon your concerns for today:

_____
_____
_____

What questions do you want answered at this visit?

_____
_____
_____
_____

Are you currently trying to conceive?
- ☐ No
- ☐ Yes

If yes, How long have you been trying to conceive?: _____

Have you tried to monitor your ovulation?
- ☐ No
- ☐ Yes

If yes, were you using:
- ☐ Basal body temperature
- ☐ Ovulation predictor kits
- ☐ Other: _____

Menstrual History

Menstrual cycle pattern (check all that apply)

- ☐ Regular periods
- ☐ Irregular periods
- ☐ Spotting before periods
- ☐ No periods
- ☐ Heavy periods
- ☐ Light periods
- ☐ Bleeding between periods

Number of days between the starts of one period to the start of the next period: _____ days

How many days of bleeding do you have? _____days

Dates of the 1st day of your last 2 menstrual periods: ____/____/____; ____/____/____

Age when you had your first period: _____ years old

Age when you first noticed:

Breast development	_____ years old
Pubic hair	_____ years old
Underarm hair	_____ years old

How many periods do you have per year? _____

Do you need medication to bring on a period?

- ☐ No
- ☐ Yes

If yes, What type?: _____

If you do not have periods, at what age did you stop having them? _____ years old

Do you ever have severe cramping or pelvic pain with your periods?

- ☐ No
- ☐ Yes

If yes,

- ☐ Always
- ☐ Sometimes
- ☐ Recently
- ☐ In the past

Have you ever missed work or school due to menstrual pain?

- ☐ No
- ☐ Yes

Contraceptive History

- ☐ None
- ☐ Condoms – dates of use: _____
- ☐ Diaphragm – dates of use: _____
- ☐ IUD – dates of use: _____-
- ☐ Birth control pills – dates of use: _____
  Complications? _____

☐ Never used birth control pills
☐ Injectable contraception (Depo-Provera, Lunelle etc.) – dates of use: _____
Complications? _____
☐ Skin patch – dates of use: _____
Complications? _____
☐ Foam or Jelly?
☐ Tubal sterilization procedure (tubes tied) – date (month/year): ____/____
☐ Tubes untied – date (month/year): ____/____

Have you ever had any complications with any methods of contraception?
☐ No
☐ Yes

If yes, please explain: _____
_____

Did your mother take DES when she was pregnant with you?
☐ No
☐ Yes
☐ Don't know

Contraceptive History

Have you ever been sexually active?
☐ No
☐ Yes

How many times do you have intercourse per week?
_____ times per week
☐ None
☐ Not applicable

Have you used over-the-counter ovulation kits to time intercourse?
☐ No
☐ Yes

Do you have pain with intercourse?
☐ No
☐ Yes

Do you used lubricants (K-Y Jelly, etc.) during intercourse?
☐ No
☐ Yes

If yes, What types: _____

Have you had any of the following sexually transmitted diseased of pelvic infections? (check all that apply)
☐ Chlamydia – date: _____
☐ Gonorrhea – date: _____
☐ Herpes – date: _____
☐ Genital warts/HPV – date: _____
☐ Syphilis – date: _____
☐ HIV/AIDS – date: _____
☐ Hepatitis – date: _____
☐ Other – date: _____

Pap Smear History

Have you ever had a pap smear?
☐ Yes
☐ No

When was your last pap smear? (month and year) _____

When was your last abnormal pap smear? (month and year) _____
☐ Not applicable

Have you undergone any procedures as a result of an abnormal pap smear?
☐ No
☐ Yes

If yes, check all that apply
☐ Colposcopy
☐ Cryosurgery (freezing)
☐ Laser treatment
☐ Conization
☐ LEEP procedure

Breast Screening History

Have you ever had a mammogram?
☐ No
☐ Yes

If yes, was the result
☐ Normal
☐ Abnormal – explain: _____

Do you perform breast self exams?
☐ No
☐ Yes

Medical History

Are you allergic to any medications?
☐ No
☐ Yes

If yes, please list and describe any reactions:

_____

_____

_____

Are you allergic to any foods (peanuts, eggs etc.)?
☐ No
☐ Yes

If yes, please list and describe any reactions:

_____

_____

_____

List any medications you are taking, including over-the-counter medicines:

_____

_____

Do you take any herbal medicines/vitamins or health food store supplements?

☐ No
☐ Yes

If yes, Please list: _____

Do you have any medical problem(s)?

☐ No
☐ Yes

If yes, please list type, dates, treatments:

(1)
(2)
(3)
(4)
(5)

In relation to your last menstruation, how much were the following issues a problem for you:

	A severe problem	A major problem	A moderate problem	Some problem	A little problem	Hardly any problem	No problem
Headaches?	☐	☐	☐	☐	☐	☐	☐
Irregular menstrual periods?	☐	☐	☐	☐	☐	☐	☐
Abdominal bloating?	☐	☐	☐	☐	☐	☐	☐
Late menstrual period?	☐	☐	☐	☐	☐	☐	☐
Menstrual cramps?	☐	☐	☐	☐	☐	☐	☐
Menstrual pain?	☐	☐	☐	☐	☐	☐	☐

In the past month, how much were you. . .

	Never	Almost never	Sometimes	Fairly often	Very often
Worried or concerned about the possibility of being infertile?	☐	☐	☐	☐	☐
Worried or concerned that you might have cancer?	☐	☐	☐	☐	☐

Perinatal History

How much did you weigh at birth? _____

Were you a full-term pregnancy? ☐ Yes ☐ No: How many weeks of gestation? _____

Did your mother have a history of gestational diabetes? ☐ Yes ☐ No

Were you average, large or small for your gestational age at birth? ☐ Average ☐ Large ☐ Small

Were you breast fed? ☐ Yes ☐ No If yes, how long? _____

Did you have difficulty gaining weight during the newborn period? ☐ Yes ☐ No

Did you have any neonatal complications? ☐ Yes ☐ No

If yes, please explain: _____

Were you overweight as a child? ☐ No ☐ Yes

Were you overweight as a pre-teen? ☐ No ☐ Yes

Were you overweight as a teen? ☐ No ☐ Yes

Family History

Please indicate if any of your family members have the following conditions:

	Mom	Dad	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
Male/Female			M F	M F	M F	M F	M F
Age							
Obesity							
Overweight							
Diabetes							
Heart disease							
High cholesterol							
Stroke							
High blood pressure							
Depression							
Acne							
Acne scarring (raised scars or depressions/indentations in skin)							
Scalp hair loss/balding							
Infertility							
If Female. . .							
PCOS		N/A					
Excess body hair		N/A					
Excess facial hair		N/A					
Infrequent periods		N/A					
Recurrent miscarriages		N/A					
Breast cancer		N/A					
Uterine cancer		N/A					
Ovarian cancer		N/A					

Please add additional copies of this page if you have more than 5 siblings.

Weight, Activity and Nutrition

What is your highest adult weight? (exclude during pregnancy) _____

What is your lowest adult weight? _____

Have you had any large fluctuations in weight? (greater than 10 pounds) ☐ Yes ☐ No

☐ Gain Dates: _____ Describe: _____

☐ Loss Dates: _____ Describe: _____

Which methods have you used for weight management, if any?

(Check all that apply)

- ☐ Diet changes
- ☐ Exercise
- ☐ Weight loss supplements, herbal or alternative therapies
- ☐ Medications (prescribed by a doctor)
- ☐ Other: _____

Do you take supplements? (vitamins, herbal or nutrition supplements) ☐ Yes ☐ No Please list all supplements: _____

Are you allergic to any foods? ☐ Yes ☐ No Please list: _____

We are interested in finding out about the kinds of physical activities you do as part of your everyday life. The questions will ask you about the time you spent being physically active in the last 7 days. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the vigorous activities that you did in the last 7 days. Vigorous physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

1. During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?

_____ days per week

_____ no vigorous physical activities (Skip to question 3)

2. How much time did you usually spend doing vigorous physical activities on one of those days?

_____ hours per day

_____minutes per day

_____ don't know/Not sure

Think about all the moderate activities that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

3. During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

_____ days per week

_____ No moderate physical activities (Skip to question 5)

4. How much time did you usually spend doing moderate physical activities on one of those days?

_____ hours per day

_____ minutes per day

_____ don't know/not sure

Think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

5. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?

_____ days per week

_____ no walking (Skip to question 7)

6. How much time did you usually spend walking on one of those days?

_____ hours per day

_____ minutes per day

_____ don't know/not sure

The last question is about the time you spent sitting on weekdays during the last 7 days. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the last 7 days, how much time did you spend sitting on a week day?

_____ hours per day

_____ minutes per day

_____ don't know/not sure

Dermatology

ACNE

Overall, how oily is the skin on your face? (Choose **one** best answer; Note: If you have "combination skin", please comment on just the oilier part of your face;)

- ○ Very oily
- ○ Moderately oily
- ○ A little oily
- ○ Neither oily nor dry
- ○ Dry

Do you **currently** have acne (i.e., blackheads, pimples, zits, whiteheads, blemishes or deep painful bumps)?

- ○ Yes
- ○ No
- ○ Don't Know

Have you had acne **in the past** (i.e., blackheads, pimples, zits, whiteheads, blemishes or deep painful bumps)?

- ○ Yes
- ○ No
- ○ Don't Know

If you do **NOT** have acne and have **NEVER** had acne, please skip to the next section, page X, "Excessive Hair Growth." Otherwise, please answer the next series of questions.

At what age did your acne first start? _____ years of age

Where did your acne first start? (Choose **one** best answer)

- ○ Face
- ○ Chest
- ○ Back
- ○ Other: _____

Since it first started, how has your acne changed **overall**? (Choose **one** best answer)

- ○ Gotten worse
- ○ Stayed the same
- ○ Gotten better

Where on your body is your acne now? (Mark **all** that apply)

- ☐ Face
- ☐ Chest
- ☐ Back
- ☐ Other: _____

Does your acne cause any of the following symptoms? (Mark **all** that apply)

- ☐ Painful
- ☐ Tender to the touch
- ☐ Itchy
- ☐ Burning or stinging

On a scale of 0 to 10, how severe do you feel your acne is **today**? (Choose **one** best answer)

Totally clear	0	1	2	3	4	5	6	7	8	9	10	Worst you can imagine
	○	○	○	○	○	○	○	○	○	○	○	

On a scale of 0 to 10, how severe do you feel your acne is on an **"average" day**? (Choose **one** best answer)

Totally clear	0	1	2	3	4	5	6	7	8	9	10	Worst you can imagine
	○	○	○	○	○	○	○	○	○	○	○	

MODIFYING FACTORS

Do you experience periodic "breakouts" or "flares" of your acne? (Mark **one** best answer)

- ○ Yes
- ○ No
- ○ Don't Know

How do you believe the following factors affect your acne?
(Please choose **one** best answer for each question below. If you do not know, please indicate "Don't Know".)

	Definitely Makes Worse	Probably Makes Worse	No Effect	Probably Makes Better	Definitely Makes Better	Don't Know
Menstrual cycle ○ Periods too irregular to tell	○	○	○	○	○	○
When does the breakout occur relative to your period? (Choose **one** best answer) ○ Two weeks before I get my period ○ One week before I get my period ○ During the week of my period ○ One week after my period has finished						
Diet	○	○	○	○	○	○
Please specify foods: _____ _____						
Stress	○	○	○	○	○	○
Exercise	○	○	○	○	○	○
Smoking ○ Not Applicable	○	○	○	○	○	○
Alcohol consumption ○ Not Applicable	○	○	○	○	○	○
Heat	○	○	○	○	○	○
Humidity	○	○	○	○	○	○
Skin products (makeup, sunscreen; etc.)	○	○	○	○	○	○
Hair products (hair spray, gel, mousse; etc.)	○	○	○	○	○	○
Poor facial hygiene (i.e., not washing face enough)	○	○	○	○	○	○
Other (please specify): _____	○	○	○	○	○	○

TREATMENT HISTORY

Are you **currently** (used within the past 2 weeks) using **ANY** medications (prescription or over-the-counter) to treat your acne?

- ○ Yes
- ○ No

If yes, please indicate which of the following medications you are **currently** using: (Mark **all** that apply)

☐ **Benzoyl peroxide**
Examples include: Proactiv, Benzac, Brevoxyl, Clean & Clear Persa-Gel, Clearasil Acne Treatment, Neutrogena On the Spot, Oxy, PanOxyl, etc. (If you use a combination antibiotic/benzoyl peroxide product, please enter it in the section below called "Antibiotics, topical")

Prescription status:
- ○ By prescription
- ○ Over-the-counter

Formulation:
- ○ Leave-on product (e.g., gel)
- ○ Wash

If you know it, please enter the name of your benzoyl peroxide product: _____

☐ **Retinoid, topical** (applied to skin)
(Choose **one** of the following products)

○ Tretinoin, generic
○ Adapalene (Differin)
○ Other, please specify: _____

○ Tretinoin (Retin-A Micro)
○ Tazarotene (Tazorac)

☐ **Antibiotic, topical** (applied to skin)
(Choose **one** of the following products)

○ Clindamycin alone
○ Erythromycin alone
○ Other, please specify: _____

○ Clindamycin/benzoyl peroxide (Duac, Benzaclin)

☐ **Other topical products** (applied to skin)
(Mark **all** that apply)

☐ Azelaic acid
☐ Salicylic acid
☐ Other, please specify: _____

☐ Glycolic acid
☐ Sulfur/Sodium sulfacetamide

☐ **Antibiotic, oral** (taken by mouth)
(Choose **one** of the following products)

○ Tetracycline
○ Doxycycline
○ Minocycline
○ Other, please specify: _____

○ TMP/SMX (Septra, Bactrim)
○ Cephalexin (Keflex)
○ Erythromycin

☐ **Hormonal contraceptive**
(Choose **one** of the following products)

○ Birth control pill
○ Contraceptive implant
○ Intrauterine device
→ Please specify name: _____
○ NuvaRing
○ OrthoEvra patch
○ Depo-Provera shot
○ Other, please specify: _____

☐ **Spironolactone** (Aldactone)
(Please indicate total daily dose)

○ 25 mg Daily
○ 50 mg Daily
○ Other, please specify: _____

○ 100 mg Daily
○ 200 mg Daily

☐ **Isotretinoin** (taken by mouth)
Examples include: Accutane, Sotret, Claravis, Amnesteem

Date current course started: _____ / _____
Month Year

☐ **Other treatment not listed**

Please specify: _____

Have you used **ANY** medications (prescription or over-the-counter) **in the past** (stopped more than 2 weeks ago) to treat your acne?

○ Yes
○ No

If yes, please indicate which of the following medications you have used **in the past**: (Mark **all** that apply)

☐ **Benzoyl peroxide** (Mark **all** that apply)
Examples include: Proactiv, Benzac, Brevoxyl, Clean & Clear Persa-Gel, Clearasil Acne Treatment, Neutrogena On the Spot, Oxy, PanOxyl, etc. (If you use a combination antibiotic/benzoyl peroxide product, please enter it in the section below called "Antibiotics, topical")

Prescription status:
☐ By prescription
☐ Over-the-counter

Formulation:
☐ Leave-on product (e.g., gel)
☐ Wash

If you know it, please enter the name(s) of your benzoyl peroxide product(s): _____

☐ **Retinoid, topical** used in the past
(Mark **all** that apply)

☐ Tretinoin, generic
☐ Adapalene (Differin)
☐ Other, please specify: _____

☐ Tretinoin (Retin-A Micro)
☐ Tazarotene (Tazorac)

☐ **Antibiotic, topical** used in the past
(Mark **all** that apply)

☐ Clindamycin alone
☐ Erythromycin alone
☐ Other, please specify: _____

☐ Clindamycin/benzoyl peroxide (Duac, Benzaclin)

☐ **Other topical products** used in the past
(Mark **all** that apply)

☐ Azelaic acid
☐ Salicylic acid
☐ Other, please specify: _____

☐ Glycolic acid
☐ Sulfur/Sodium sulfacetamide

☐ **Antibiotic, oral** used in the past
(Mark **all** that apply)

☐ Tetracycline
☐ Doxycycline
☐ Minocycline
☐ Other, please specify: _____

☐ TMP/SMX (Septra, Bactrim)
☐ Cephalexin (Keflex)
☐ Erythromycin

☐ **Hormonal contraceptive** used in the past (Mark **all** that apply)	☐ Birth control pill ☐ Contraceptive implant ☐ Intrauterine device ☐ NuvaRing ☐ OrthoEvra patch ☐ Depo-Provera shot ☐ Other, please specify: _____	→ Please specify name(s): _____
☐ **Spironolactone** (Aldactone) used in the past (Please indicate total daily doses you've taken)	☐ 25 mg Daily ☐ 50 mg Daily ☐ Other, please specify: _____	☐ 100 mg Daily ☐ 200 mg Daily
☐ **Isotretinoin** used in the past Examples include: Accutane, Sotret, Claravis, Amnesteem	Number of courses completed: _____ courses Date last course stopped: _____ / _____ (Month / Year)	
☐ **Other treatment not listed** used in the past	Please specify: _____	

ACNE QUALITY OF LIFE

ACNE-QOL: THESE QUESTIONS CONCERN HOW THE ACNE ON YOUR FACE HAS CHANGED AND HOW YOU HAVE FELT ABOUT YOUR ACNE **DURING THE PAST WEEK**.

Place an X in one box for each question	Not at all	A little bit	Some-what	A good bit	Quite a bit	Very much	Extre-mely
1. In the past WEEK, how unattractive did you feel because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
2. In the past WEEK, how embarrassed did you feel because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
3. In the past WEEK, how self-conscious (uneasy about oneself) did you feel about your facial acne?	☐	☐	☐	☐	☐	☐	☐
4. In the past WEEK, how upset were you about having facial acne?	☐	☐	☐	☐	☐	☐	☐
5. In the past WEEK, how annoyed did you feel at having to spend time every day cleaning and treating your face because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
6. In the past WEEK, how dissatisfied with your self-appearance did you feel because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
7. In the past WEEK, how concerned or worried were you about not looking your best because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
8. In the past WEEK, how concerned or worried were you that your acne medication/products were working fast enough in clearing up the acne on your face?	☐	☐	☐	☐	☐	☐	☐

Place an X in one box for each question	Not at all	A little bit	Some-what	A good bit	Quite a bit	Very much	Extre-mely
9. In the past WEEK, how bothered did you feel about the need to always have medication or cover-up available for the acne on your face?	☐	☐	☐	☐	☐	☐	☐
10. In the past WEEK, how much was your self-confidence (sure of yourself) negatively affected because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
11. In the past WEEK, how concerned or worried were you about meeting new people because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
12. In the past WEEK, how concerned or worried were you about going out in public because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
13. In the past WEEK, how much was socializing with people a problem for you because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
14. In the past WEEK, how much was interacting with the opposite sex (or same sex if gay or lesbian) a problem for you because of your facial acne?	☐	☐	☐	☐	☐	☐	☐
15. In the past WEEK, how concerned or worried were you about scarring from your facial acne?	☐	☐	☐	☐	☐	☐	☐
16. In the past WEEK, how oily was your facial skin?	☐	☐	☐	☐	☐	☐	☐

Place an X in one box for each question	None	Very few	Some	Moderate amount	A lot	A whole lot	Exten-sive
17. In the past WEEK, how many bumps did you have on your face?	☐	☐	☐	☐	☐	☐	☐
18. In the past WEEK, how many bumps full of pus did you have on your face?	☐	☐	☐	☐	☐	☐	☐
19. In the past WEEK, how much scabbing from your facial acne did you have?	☐	☐	☐	☐	☐	☐	☐

EXCESSIVE HAIR GROWTH

How does your skin respond to sunlight? (Choose **one** best answer)

Fair Skin ← → **Dark Skin**

○	○	○	○	○	○
Always burns, Never tans	Always burns, Minimal tan	Minimal burn, Gradual tan	Minimal burn, Tans well	Rarely burns, Profuse tan	Never burns, Tans deeply

What is your natural scalp hair color? (Choose **one** color; if not black, select a hue)

- ○ Black
- ○ Brown → ○ Light ○ Dark
- ○ Blonde → ○ Light ○ Dark
- ○ Red → ○ Light ○ Dark

Do you feel that you have excessive facial or body hair growth?

- ○ Yes (Continue to next question)
- ○ No (Please skip to Page X)

How old where you when you first noticed the excessive facial or body hair growth?

_____ years of age

Did the excessive facial or body hair growth start abruptly or more gradually?

- ○ Abruptly
- ○ More gradually
- ○ Don't Know

Since it first started, has the excessive facial or body hair growth:

- ○ Gotten worse
- ○ Stayed the same
- ○ Gotten better

When the excessive facial or body hair growth started, was it also associated with a deepening of your voice?

- ○ Yes
- ○ No

What methods are you **currently using or have you used** to remove hair in the following anatomic areas? (Mark **all** that apply)

	Bleach	Shave	Wax	Pluck	Chem-ical*	Electro-lysis	Laser	Vaniqa†	Has the area been treated in last 7 days?	
Upper lip	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Chin/Jaw	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Central chest	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Upper abdomen (above navel)	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Lower abdomen (below navel)	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Upper back	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Lower back	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Upper arm (above elbow)	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No
Thighs (above knee)	☐	☐	☐	☐	☐	☐	☐	☐	○ Yes	○ No

*Chemical depilatories (e.g., Neet, Nair, etc.); †Eflornithine hydrochloride

Are you **currently using or have you used** any of the following medications **specifically** for your excessive facial or body hair growth? (Mark **all** that apply; if none, please mark "None of the above")

☐ **Insulin sensitizer** specifically to treat excessive hair growth (Mark **all** that apply)
- ☐ Metformin (Glucophage)
- ☐ Rosiglitazone (Avandia)
- ☐ Pioglitazone (Actos)
- ☐ Troglitazone (Rezulin)
- ☐ Other, please specify: _____

☐ **Other hormonal therapy** specifically to treat excessive hair growth (Mark **all** that apply)
- ☐ Birth control pill, specify: _____
- ☐ Finasteride
- ☐ Spironolactone (Aldactone)
- ☐ Flutamide
- ☐ Cyproterone (Diane)
- ☐ Other, please specify: _____

☐ **Other treatment not listed** specifically to treat excessive hair growth, please specify: _____

☐ **None of the above**

	Not important	Of little importance	Moderately important	Very important	Extremely important
How important is it for you to treat your excessive hair growth?	☐	☐	☐	☐	☐

Do you think any medications have **worsened** your excessive facial or body hair growth?
- ○ Yes, please specify: _____
- ○ No

EXCESSIVE HAIR GROWTH QUALITY OF LIFE

These questions concern how excessive hair growth has bothered you during the past FOUR WEEKS:

Place an X in one circle for each question	Never bothered ↓						Always bothered ↓
1. Your excessive hair growth **itching** . . .	○	○	○	○	○	○	○
2. Your excessive hair growth **burning** or **stinging** . . .	○	○	○	○	○	○	○
3. Your excessive hair growth **hurting** . . .	○	○	○	○	○	○	○
4. Your excessive hair growth being **irritated** . . .	○	○	○	○	○	○	○
5. The **persistence/reoccurrence** of your excessive hair growth . . .	○	○	○	○	○	○	○
6. **Worry** about your excessive hair growth . . . (For example: that it will spread, get worse, scar, be unpredictable, etc.)	○	○	○	○	○	○	○
7. The **appearance** of your excessive hair growth . . .	○	○	○	○	○	○	○
8. **Frustration** about your excessive hair growth . . .	○	○	○	○	○	○	○
9. **Embarrassment** about your excessive hair growth . . .	○	○	○	○	○	○	○
10. **Being annoyed** about your excessive hair growth . . .	○	○	○	○	○	○	○
11. **Feeling depressed** about your excessive hair growth . . .	○	○	○	○	○	○	○
12. The effects of your excessive hair growth on your **interactions with others** . . . (For example: interactions with family, friends, close relationships, etc.)	○	○	○	○	○	○	○

Place an X in one circle for each question	Never bothered ↓			●			Always bothered ↓
13. The effects of your excessive hair growth on your **desire to be with people**. . .	○	○	○	○	○	○	○
14. Your excessive hair growth making it hard to **show affection** . . .	○	○	○	○	○	○	○
15. The effects of your excessive hair growth on your **daily activities** . . .	○	○	○	○	○	○	○
16. Your excessive hair growth making it hard to **work or do what you enjoy** . . .	○	○	○	○	○	○	○
17. **Feeling unfeminine or unwomanly** because of your excessive hair growth . . .	○	○	○	○	○	○	○
18. **Avoiding activities** because of your excessive hair growth . . . (For example: sunbathing, sports, sexual contact, etc.)	○	○	○	○	○	○	○

During the past <u>FOUR WEEKS</u> how bothered would you have been if:

Place an X in one circle for each question	Not bothered at all ↓			●			Bothered all the time ↓
19. You were **unable to remove** your excessive hair . . . (For example: with shaving, plucking, waxing, etc.)	○	○	○	○	○	○	○

How often during the past <u>FOUR WEEKS</u> would these statements have described you?

Place an X in one circle for each question	Never ↓			●			All the time ↓
20. I think **other people notice** my excessive hair growth . . .	○	○	○	○	○	○	○
21. My excessive hair growth makes me **feel abnormal** . . .	○	○	○	○	○	○	○
22. I think **people make fun of me** because of my excessive hair growth . . .	○	○	○	○	○	○	○
23. I think people see my excessive hair growth and think I am **dirty** . . .	○	○	○	○	○	○	○
24. I think people talk about my excessive hair growth **behind my back .** . .	○	○	○	○	○	○	○
25. My excessive hair growth makes me look **disfigured** . . .	○	○	○	○	○	○	○

SCALP HAIR LOSS

Are you experiencing scalp hair loss?
○ Yes
○ No

Do any of your close biological relatives have scalp hair loss? (Mark **<u>all</u>** that apply)
☐ Father ☐ Brother
☐ Mother ☐ Sister

SKIN CANCER HISTORY

Do you have a personal history of:
Melanoma? ○ No ○ Yes
Other skin cancer? ○ No ○ Yes, specify type: _____

Do you have a family history of:
Melanoma? ○ No ○ Yes
Other skin cancer? ○ No ○ Yes, specify type: _____

Personal Experiences

For each of the following questions, please pick the answer that best describes your answer.

In general, would you say your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

The following questions are about activities you might do during a typical day. Does <u>your health now limit</u> you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. <u>Moderate activities</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. Climbing <u>several</u> flights of stairs	☐	☐	☐

During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health?</u>

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Were limited in the <u>kind</u> of work or other activities	☐	☐	☐	☐	☐

During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. <u>Accomplished less</u> than you would like	☐	☐	☐	☐	☐

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
b. Did work or activities <u>less carefully than usual</u>	☐	☐	☐	☐	☐

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the <u>past 4 weeks</u>. . .

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐
c. Have you felt down and depressed?	☐	☐	☐	☐	☐

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

In the past month, how often have you. . .

	Never	Almost never	Sometimes	Fairly often	Very often
Felt that you were unable to control the important things in your life?	☐	☐	☐	☐	☐
Felt confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
Felt that things were going your way?	☐	☐	☐	☐	☐
Felt difficulties were piling up so high that you could not overcome t hem?	☐	☐	☐	☐	☐

Please read the following statements carefully, then pick out the one statement in each group which best describes the way you have been feeling during the past 2 weeks, including today! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle the statement which has the largest number.

1.

0 I do not feel sad.

1 I feel sad much of the time.

2 I feel sad all the time.

3 I feel so sad or unhappy that I can't stand it.

2.

0 I am not discouraged about my future.

1 I feel more discouraged about my future than I used to be.

2 I do not expect things to work out for me.

3 I feel my future is hopeless and will only get worse.

3.

0 I do not feel like a failure.

1 I have failed more than I should have.

2 As I look back, I see a lot of failures.

3 I feel I am a total failure as a person.

4.

0 I get as much pleasure as I ever did from the things I enjoy

1 I don't enjoy things as much as I used to.

2 I get very little pleasure from the things I used to enjoy.

3 I can't get any pleasure from the things I enjoy.

5.

0 I feel the same about myself as ever.

1 I have lost confidence in myself.

2 I am disappointed in myself.

3 I dislike myself.

6.

0 I don't criticize or blame myself more than usual.

1 I am more critical of myself than I used to be.

2 I criticize myself for all of my faults

3 I blame myself for everything bad that happens

7.

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

These questions ask about the way you usually see things.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I feel that I'm a person of worth, at least on an equal basis of others.	☐	☐	☐	☐	☐
I feel that I have a number of good qualities.	☐	☐	☐	☐	☐
All in all, I am inclined to feel I'm a failure.	☐	☐	☐	☐	☐
I am able to do things as well as most other people.	☐	☐	☐	☐	☐
I feel I do not have much to be proud of.	☐	☐	☐	☐	☐
I take a positive attitude toward myself.	☐	☐	☐	☐	☐

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
On the whole, I am satisfied with myself.	☐	☐	☐	☐	☐
I certainly feel useless at times.	☐	☐	☐	☐	☐
I wish I could have more respect for myself.	☐	☐	☐	☐	☐
At times, I think I am no good at all.	☐	☐	☐	☐	☐

Thank you for taking the time to fill out this questionnaire. Your answers will help us understand your personal concerns and problems better.